TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GENESIS MEDICAL NETWORKS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-98-A782

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 24, 1998

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for consideration in this review.

Amount in Dispute: $2,475.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Commission's 6/1/95 Spine Treatment Guideline, on p 48, indicates that 6 months from the date of injury is the end of the tertiary level of care. . . . Work Conditioning is not listed as an appropriate intervention for the tertiary level of care. . . . Peer review determined that no further treatment was appropriate or necessary after work hardening. . . . It is the treating doctor's responsibility to determine if the claimant is appropriate for a work hardening program. The treating doctor made this determination and advanced the claimant to work hardening. During the course of work hardening the treating doctor requested an additional 2 weeks of work hardening which the Fund approved. The treating doctor then continued the claimant in work hardening after the preauthorization expired and moved him into work conditioning for approximately 5 more weeks, without notification to the Fund. . . . The treating doctor's rationale . . . by prescribing a course of work conditioning after work hardening, was that no work was available to fit what the claimant could do. . . . It is the Fund's position that this does not clinically substantiate the need for 5 weeks of non-authorized work conditioning after a) 10 weeks of work hardening, b) after two months of physical therapy, c) without any positive diagnostic tests, and d) without any indication of radiculopathy, neuropathy, or myelopathy."

Response Submitted by: Texas Workers' Compensation Insurance Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 1997 to March 31, 1997	Work Conditioning Services	$2,475.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §141.1 sets out procedures for requesting a benefit review conference.
3. The insurance carrier denied payment for the disputed services with the following denial explanations:
   - U – UNNECESSARY MEDICAL TREATMENT
   - A – PREAUTHORIZATION NOT OBTAINED
   - F – REIMBURSED IN ACCORDANCE WITH THE TEXAS MEDIAL FEE GUIDELINE.
   - A peer review has been done. This procedure would be not medically necessary.

Issues

1. Was the request for dispute resolution submitted no later than one year after the disputed date(s) of service?
2. Did the requestor provide a position summary regarding the disputed issues?
3. Has the requestor supported that additional reimbursement is due?

Findings

1. 28 Texas Administrative Code §133.305(a), effective June 3, 1991, 16 *Texas Register* 2830, states: "A request for review of medical services and dispute resolution, as described in the Texas Workers' Compensation Act (the Act), §8.26, shall be submitted to the commission at the division of medical review in Austin, no later than one calendar year after the date(s) of service in dispute." The applicability of the one-year filing deadline from the date(s) of service in dispute was confirmed in the court's opinion in *Hospitals and Hospital Systems v. Continental Casualty Company*, 109 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). The request for medical dispute resolution was received by the division of medical review on March 24, 1998. This date is greater than one year from after dates of service March 10, 1997 through March 21, 1997. The request for these dispute resolution of these services was not timely submitted to the division for consideration. The Division concludes that the requestor has not met the requirements of §133.305(a) and has waived the right to medical dispute resolution for those dates of service. Therefore service dates March 10, 1997 through March 21, 1997 will not be considered in this review.

   However, the request for dispute resolution of services rendered from March 24, 1997 through March 31, 1997 was timely submitted in accordance with the requirements of §133.305(a); therefore, these services will be considered in this review.

2. The requestor has not submitted the request in the form and manner required by Division rule. 28 Texas Administrative Code §133.305(d)(10), effective June 3, 1991, 16 Texas Register 2830, requires that the request shall include "a summary of the requesting party's position regarding the dispute." Review of the submitted documentation finds that the request does not include a summary of the requesting party's position regarding the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(10).

3. The insurance carrier denied disputed services with claim adjustment reason code U – "Unnecessary Treatment (with peer review)." Upon reconsideration of the medical bills for service dates March 24 through March 31, 1997, the insurance carrier maintained their denial of the disputed services with the explanation: "A peer review has been done. This procedure would be not medically necessary."

   28 Texas Administrative Code §133.308(a)(1) requires that Dispute resolution requests filed prior to June 1, 2012 shall be resolved in accordance with the statutes and rules in effect at the time the request was filed. The applicable rule for resolving the medical necessity of the services in this dispute is the Division's former *Spine Treatment Guideline* at 28 Texas Administrative Code §134.1001, effective June 1, 1995, 20 *Texas Register* 2290.

   Review of the submitted information finds that the requestor has not presented sufficient documentation to support that the disputed services meet the requirements of §134.1001. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	September 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.